Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
1206 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380-5010

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-2940-01

MFDR Date Received
May 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Northwest Texas Hospital billed Texas Mutual $31,097.50 on 11/04/10 and Texas Mutual paid Northwest Texas Hospital a total of $4,383.44. However, the proper reimbursement under the terms of Northwest Texas Hospital contract was $7,383.88."

Amount in Dispute: $3,000.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no contract with the requestor for the disputed dates. . . . The total APC payment for these OPPS covered services is approximately $2,000.00. When these covered APC payment rates are multiplied by 200% on gets $4,000.00. Texas Mutual paid $4,383.44. The additional payment beyond the $4,000.00 comes from payment of those services that are covered by Medicare under a fee schedule other than OPPS. . . . Absent any information on the contract or the above APC 'allowable,' no further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 East Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2010 to October 28, 2010	Outpatient Hospital Services	$3,000.44	$3,000.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – DUPLICATE CLAIM/SERVICE
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 356 – THIS ALLOWANCE WAS BASED ON THE PART B FEE SCHEDULE AMOUNT
   - 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED
   - 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE
   - B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
   - 446 – THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 736 – "DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION." The requestor's position statement asserts that "the proper reimbursement under the terms of Northwest Texas Hospital contract was $7,383.88." The respondent's position statement asserts that "Texas Mutual has no contract with the requestor for the disputed dates. Nor has the requestor provided a contract or pertinent portions of a contact substantiating its allegation that Texas Mutual failed to abide by the terms of that contract. Instead, the requestor provided hearsay." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Per Medicare policy, procedure code 96361 is an add-on code for each additional hour of Intravenous

infusion, hydration. Medicare policy requires that this code be reported with a corresponding primary procedure code, 96360. However, the required primary procedure code was not reported on the bill. Separate payment is not recommended.

- Per Medicare policy, procedure code 96374 is unbundled. This procedure is a component service of procedure code 26910 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, the provider did not submit medical documentation to support the use of modifier 59. Separate payment is not recommended.
- Per Medicare policy, procedure code 96361 is an add-on code for each additional hour of Intravenous infusion, hydration. Medicare policy requires that this code be reported with a corresponding primary procedure code, 96360. However, the required primary procedure code was not reported on the bill. Separate payment is not recommended.
- Procedure code 96375 was denied by the insurance carrier with reason codes B15 – "THIS SERVICE/ PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ ADJUDICATED" and 446 – "THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED." This procedure code is an add-on code for each additional sequential intravenous push of a new substance/drug. Medicare policy requires that this code be reported with a corresponding primary procedure code. Procedure code 96374 is a valid corresponding primary procedure code, which was billed on the same bill. The insurance carrier's denial reasons are not supported. However, the primary service, code 96374, is a component service of procedure code 26910. Therefore, this add-on service is also unbundled. Payment for this service is included in the payment for the primary surgery. Separate payment is not recommended.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Per Medicare policy, procedure code 96361 is an add-on code for each additional hour of Intravenous infusion, hydration. Medicare policy requires that this code be reported with a corresponding primary procedure code, 96360. However, the required primary procedure code was not reported on the bill. Separate payment is not recommended.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Per Medicare policy, procedure code 96361 is an add-on code for each additional hour of Intravenous infusion, hydration. Medicare policy requires that this code be reported with a corresponding primary procedure code, 96360. However, the required primary procedure code was not reported on the bill. Separate payment is not recommended.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15. The recommended payment is $15.15.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility

payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. The recommended payment is $13.93.

- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.62. 125% of this amount is $7.02. The recommended payment is $7.02.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.60. 125% of this amount is $10.75. The recommended payment is $10.75.
- Procedure code 87070 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.34. 125% of this amount is $15.43. The recommended payment is $15.43.
- Procedure code 87075 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $13.55. 125% of this amount is $16.94. The recommended payment is $16.94.
- Procedure code 87205 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $6.11. 125% of this amount is $7.64. The recommended payment is $7.64.
- Procedure code 88305 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0343, which, per OPPS Addendum A, has a payment rate of $35.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.44. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $18.30. The non-labor related portion is 40% of the APC rate or $14.29. The sum of the labor and non-labor related amounts is $32.59. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $32.59. This amount multiplied by 200% yields a MAR of $65.18.
- Procedure code 88311 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0342, which, per OPPS Addendum A, has a payment rate of $10.42. This amount multiplied by 60% yields an unadjusted labor-related amount of $6.25. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $5.33. The non-labor related portion is 40% of the APC rate or $4.17. The sum of the labor and non-labor related amounts is $9.50. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $9.50. This amount multiplied by 200% yields a MAR of $19.00.
- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of

$26.94. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $22.99. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $40.95. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $40.95. This amount multiplied by 200% yields a MAR of $81.90.

- Procedure code 26910 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0054, which, per OPPS Addendum A, has a payment rate of $1,903.38. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,142.03. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $974.61. The non-labor related portion is 40% of the APC rate or $761.35. The sum of the labor and non-labor related amounts is $1,735.96. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.264. This ratio multiplied by the billed charge of $10,188.10 yields a cost of $2,689.66. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,735.96 divided by the sum of all APC payments is 93.04%. The sum of all packaged costs is $4,940.05. The allocated portion of packaged costs is $4,596.23. This amount added to the service cost yields a total cost of $7,285.89. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,247.96. 50% of this amount is $2,123.98. The total APC payment for this service, including outlier payment, is $3,859.94. This amount multiplied by 200% yields a MAR of $7,719.88.
- Procedure code 90661 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code 90471 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $13.14. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $23.41. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $23.41. This amount multiplied by 200% yields a MAR of $46.82.
- Per Medicare policy, procedure code G0237 is unbundled. This procedure is a component service of procedure code 94760 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- HCPCS code G0379 has a status indicator of Q3, which denotes conditionally packaged codes that may be separately paid or paid through a composite APC if OPPS criteria are met; payment is packaged into a single payment for specific combinations of service. Per Medicare policy, separate payment is not allowed for HCPCS code G0379 when billed on the same date of service as a procedure with status indicator T. This service was billed on the same date as procedure code 26910 above, which has a status indicator of T. OPPS criteria for separate payment have not been met. Payment for HCPCS code G0379 is therefore packaged into the payment for the primary service. Separate payment is not recommended.
- Procedure code 90471 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.8534 yields an adjusted labor-related amount of $13.14. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $23.41. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including any applicable outlier payment, is $23.41. This amount multiplied by 200% yields a MAR of $46.82.

4. The total allowable reimbursement for the services in dispute is $8,070.21. The amount previously paid by the insurance carrier is $4,383.44. The requestor is seeking additional reimbursement in the amount of $3,000.44. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,000.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,000.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.